



Sleep Apnea Questionnaire

Do you wonder about how well you really sleep? Dr. Pete Nathe offers this sleep questionnaire to measure your daytime sleepiness. Please fill out our form to help assess your level of daytime sleepiness. We invite you to contact our office at (509)941-2957 if you have any questions, and to schedule a consultation with our caring dentist.

Using the rating scale provided, please select the answer that most closely applies to you.

Answer Key:

- 0 – Would never doze
- 1 – Slight chance of dozing
- 2 – Moderate chance of dozing
- 3 – High chance of dozing

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting in a public setting (movie theatre, meeting, etc.)	0	1	2	3
Sitting in the passenger seat of a care for more than an hour without a break	0	1	2	3
Sitting quietly after lunch (without consuming alcohol)	0	1	2	3
Stopped in traffic for a few minutes while driving	0	1	2	3

What your results indicate:

Score: _____

- If you scored between 0-10, you are within the normal range for daytime sleepiness in adults. You are mostly likely getting enough sleep at night.
- If you scored between 11-16, you are experiencing mild daytime sleepiness, and should probably try to get a little more sleep. You may also want to consider meeting with a doctor or participating in a home-based sleep study to determine the cause of your sleepiness.
- If you scored 17 or higher, you are experiencing severe daytime sleepiness. This level of sleepiness is dangerous, and you should consult with a doctor immediately to determine the cause of your sleepiness and create a treatment plan as soon as possible.

This scale should NOT be used for personal diagnosis. It is intended to be used as a tool to help you identify the level of your daytime sleepiness. Daytime sleepiness is often a symptom of a sleep disorder. The underlying medical conditions that cause daytime sleepiness are often easy to diagnose and treat.

If you scored 11 or higher, we recommend that you contact our office to schedule a consultation with Dr. Nathe. Please print this questionnaire and bring a copy of the results with you to your appointment. You may also want to consider writing down a list of all your symptoms so that you can describe them as clearly as possible. This will aid in your diagnosis.

Name: _____

Date: _____

Print Name: _____

Phone number: _____